their parents reported knowing this. Seventy-six percent of teens who had engaged in neither oral nor vaginal sex had a parent who reported this knowledge. Overall, 65% of parents accurately reported if their adolescent had engaged in oral or vaginal sex (congruence). Parent-teen sexual health communication was associated with congruence (OR 2.9). Congruence was also associated with teen comfort discussing sexual health, number of sexual health topics discussed, age of teen at first sexual health conversation, teen gender, and teen age. Teens who reported talking to their parents about sexual health were 5.2 times more likely to report any condom past three months compared to those who did not report sexual health communication with their parent.

Conclusions: To design appropriate interventions aimed at improving parent-teen sexual health communication, it is important to assess not only if parents are talking to their teens about sexual health topics, but also whether communication results in accurate knowledge about teen behavior. Parental knowledge of teen sexual behaviors appears to be a marker of communication quality between parent and teen and can therefore serve as a tool by which researchers can evaluate sexual health communication. Improving such communication may increase healthy sexual behaviors among teens.

Sources of Support: None.

HEALTH POLICY, QUALITY IMPROVEMENT, AND LEGAL/ETHICAL ISSUES

177.

PROVIDER ATTITUDES, KNOWLEDGE AND PRACTICE OF EXPEDITED PARTNER THERAPY (EPT) FOR ADOLESCENTS TREATED FOR CHLAMYDIAL INFECTION IN VARYING STATE POLICY ENVIRONMENTS

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Purpose: Adolescents in the United States are disproportionately affected by sexually transmitted infections (STIs). Expedited Partner Therapy (EPT), treatment of the sexual partner(s) of a patient with an STI without intervening clinical exam or professional counseling, is effective in preventing reinfection, but is not used frequently for adolescents. The purpose of this study was to evaluate provider knowledge of state legal policy around EPT, current practice, and potential barriers to provision of EPT.

Methods: Anonymous, closed-ended, computer-based survey administered via REDCap software to randomly selected providers in the AMA database who care for adolescents and practice in one of three differing state legal environments. States were grouped based on a revised framework from the CDC as follows: EPT is (A) explicitly legal (NY, OR, TN); (B) permissible but not directly referenced in law (PA, MS, NV); or (C) potentially allowable (NJ, GA, MT). Survey items assessed provider demographics; knowledge of EPT legal environment in physician's practicing state; provider attitudes around EPT and potential barriers to provision of EPT in adolescents ages 13-17. Analyses were performed using STATA 12.0.

Results: Emails were sent to 7789 physicians; of the 1710 (22%) opened emails there were 195 evaluable responses. 61% were female; 83% spent at least three-quarters of their time in clinical practice. The majority (59%) completed a pediatrics residency and 5% completed an adolescent medicine fellowship. With respect to state policy groupings, 44% practiced in group A, 31% in B, and 24% in C. Only 20% reported a history of using EPT; those in group A were more likely to have used EPT compared to groups B and C (OR 5.5, 95% CI 2.3, 14.2). Half in group A correctly reported EPT was legal in their state; 22% in group C incorrectly stated EPT was legal in their state; and 88% in group B reported they did not know about legality. 63% reported they were supportive of EPT for adolescents; providers in group A were significantly more likely to report supporting EPT than those in groups B and C (OR 2.6, 95% CI 1.3, 5.2). Commonly cited barriers to EPT were missed opportunity to counsel partners (82%), difficulty insuring delivery of medication (79%), and concern the partner may not understand contraindications (77%); results did not differ by state grouping. Few participants were concerned that EPT violates medical practice guidelines (19%). Very few (13%) agreed with the statement, "there are other laws or policies in my state or institution that would make it difficult to provide EPT"; with group B least likely to agree.

Conclusions: Results suggest that despite positive attitudes towards EPT, the treatment is not commonly used for adolescents. Although those providers in supportive state legal environments were more likely to use EPT, providers in all policy environments had similar concerns about barriers to EPT. Further investigation is needed to better understand the impact of laws on EPT practices. Ultimately, this will inform policy recommendations and intervention development to increase provision of EPT to adolescents.

Sources of Support: Leonard Davis Institute of Health Economics, UPenn.

178.

BRIEF ELECTRONIC SCREENING FOR ADOLESCENTS IN PRIMARY HEALTH CARE

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Purpose: The use of alcohol, tobacco, and other drugs (ATOD) among adolescents has been an ongoing public health concern for decades. The 2009 National Survey on Drug Use and Health (NSDUH) estimated that 21.8 million Americans aged 12 or older were current illicit drug users, about 8.7% of the population. The call for healthcare providers and primary care settings to become more active in the prevention and treatment of ATOD among adolescents has been made for over a decade and is especially important with the advent of the Affordable Care Act (ACA). The American Academy of Pediatrics strongly supports the use of screening, brief intervention, and referral to treatment with adolescents; however, providers and staff are concerned with screening negatively impacting clinic flow. The purpose of this study was to explore the use of electronic screening in adolescent specialty care clinics to assess the feasibility of their use.

Methods: Data were collected as part of the Adolescent Electronic Preventive Screening in Primary Health Care Settings pilot study. Participants ages 10-21 (68% female) completed a brief electronic screener in an adolescent primary care clinic prior to being seen by a physician (N = 98).The average age of adolescents screened was 16.3 years old, with the primary reason for visit was either a checkup or follow up. After completing the screener, and before having contact with any health care provider, printed results from the screener were given to the nursing staff and physician to

highlight any specific issues that needed to be addressed during that visit. Healthcare staff then utilized the information gained from the screener to further direct the office visit of the patient, specifically addressing issues and needs identified by the screener.
Results: Prior to study implementation, clinic staff noted concern in utilizing screeners during due to the possibility of interfering with clinic flow. Adolescents in our sample took an average of 7:52 to complete one of three randomly assigned screeners (SD = 6:44). However, we found a statistically significant difference in the amount of time it took to complete the screeners ($F(2,91) = 4.37$, $p = .015$). A Tukey post-hoc test revealed that the time to complete the Bright Futures screener was significantly higher than the GAIN-Q (10:22 ± 5:27 min, $p = .011$). The Bright Futures screener took the longest for the 11-14 year old category with an average completion time of 16:40 (SD = 1:42). The difference in time to completion was statistically significant compared to the GAIN (16:40 ± 5:27 min, $p = .012$), but was not found to be statistically significant compared to the YES.
Conclusions: Electronic screening in an adolescent specialty care setting identified a number of issues that needed to be addressed during the consult, and overall had a positive effect on the quality of care for adolescents. Utilizing electronic screeners in this manner did not interrupt the clinical flow, and provided immediate and easy to interpret information for providers. Responses from providers indicated that the electronic screening process helped to identify areas needing intervention while also providing information on areas for reinforcement.
Sources of Support: LEAH training grant (HRSA/MCHB T7100008).

179.

PHYSICIAN KNOWLEDGE AND ATTITUDES AROUND ADOLESCENT CONFIDENTIALITY

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Purpose: Minor adolescent patients have certain legal rights to access specific medical services confidentially without parental consent or notification. We sought to assess providers' knowledge of these laws, attitudes around the provision of confidential care to minors, and barriers to providing confidential care.
Methods: Physicians from the Departments of Family Medicine, Medicine-Pediatrics, Obstetrics/Gynecology, and Pediatrics at the University of Michigan received an anonymous online survey assessing comfort in discussing sensitive subjects with adolescents, knowledge of Michigan laws on confidential care for adolescents, level of approval of these laws, and barriers to providing confidential care. Associations between demographical information, knowledge, and attitudes were explored using t-tests, ANOVA, and Pearson's correlation as appropriate.
Results: Response rate was 40% (259/650). On a scale of one (very uncomfortable) to five (very comfortable), the majority of providers felt quite comfortable addressing sexual health (mean 4.07 ± 1.12), mental health (3.97 ± 1.02), and substance use (3.89 ± 1.09) with minor patients. Providers answered just over half of the legal knowledge questions correctly (mean 56.6% ± 16.7%), with more correct answers on questions about health records vs. sexual health vs. mental health vs. substance abuse ($p = 0.03$). Providers knew more about minors' ability to consent for care vs. the laws around parental notification of care ($p = 0.00$). There was a significant difference in knowledge by specialty ($p = 0.06$), gender ($p = 0.01$), and whether or not the provider was a PCP ($p = 0.00$). Over three quarters of providers (76.6%) felt they needed additional training on confidentiality laws. The majority of providers approved of laws allowing minors to consent for confidential care (86.5% to 94.1% approval rates), while under half (40.9% to 49.4%) approved of laws allowing parental notification of this care at the physician's discretion. Only one quarter (25.7%) approved of the Michigan law mandating written parental consent for a minor to have an abortion. Parents of an adolescent child were more likely to approve of parental notification laws ($p = 0.01$). On a scale of one (strongly disagree) to five (strongly agree), most providers agreed that assured access to confidential care should be a right for adolescents (mean 4.55 ± 0.88), though were less confident that most adolescents are mature enough to consent for confidential care (mean 3.71 ± 1.06). Insurance issues, parental attitudes about confidential care/relationships with the family, and issues with the electronic medical record were found to most inhibit the provision of confidential care, while discomfort discussing sensitive issues with adolescents and time it takes to discuss confidentiality were least inhibiting.
Conclusions: Physicians feel comfortable discussing sensitive issues with minor patients and generally approve of minor consent laws, but lack knowledge about what services a minor can access confidentially. Insurance and health record issues are potentially correctable barriers to providing confidential care. Further research is needed to assess best methods to educate providers about minors' legal rights to healthcare services.
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